General Assembly

Governor's Bill No. 5042

February Session, 2022

LCO No. **647**

Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
Request of the Governor Pursuant
to Joint Rule 9

AN ACT CONCERNING HEALTH CARE COST GROWTH.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 19a-754a of the 2022 supplement to the general
2 statutes is repealed and the following is substituted in lieu thereof
3 (*Effective from passage*):

4 (a) There is established an Office of Health Strategy, which shall be
5 within the Department of Public Health for administrative purposes
6 only. The department head of said office shall be the executive director
7 of the Office of Health Strategy, who shall be appointed by the Governor
8 in accordance with the provisions of sections 4-5 to 4-8, inclusive, with
9 the powers and duties therein prescribed.

10 (b) The Office of Health Strategy shall be responsible for the
11 following:

12 (1) Developing and implementing a comprehensive and cohesive
13 health care vision for the state, including, but not limited to, a

14 coordinated state health care cost containment strategy;

15 (2) Promoting effective health planning and the provision of quality
16 health care in the state in a manner that ensures access for all state
17 residents to cost-effective health care services, avoids the duplication of
18 such services and improves the availability and financial stability of
19 such services throughout the state;

20 (3) [Directing] (A) Developing, innovating, directing and overseeing
21 health care delivery and payment models in the state that reduce health
22 care cost growth and improve the quality of patient care, including, but
23 not limited to, the State Innovation Model Initiative and related
24 successor initiatives, (B) setting an annual health care cost growth
25 benchmark and primary care target pursuant to section 3 of this act, (C)
26 developing and adopting health care quality benchmarks pursuant to
27 section 3 of this act, (D) developing strategies, in consultation with
28 stakeholders, to facilitate adherence with such benchmarks and targets
29 developed pursuant to section 3 of this act, (E) enhancing the
30 transparency of provider entities, as defined in subdivision (13) of
31 section 2 of this act, (F) monitoring the development of accountable care
32 organizations and patient-centered medical homes in the state, and (G)
33 monitoring the adoption of alternative payment methodologies in the
34 state;

35 (4) (A) Coordinating the state's health information technology
36 initiatives, (B) seeking funding for and overseeing the planning,
37 implementation and development of policies and procedures for the
38 administration of the all-payer claims database program established
39 under section 19a-775a, (C) establishing and maintaining a consumer
40 health information Internet web site under section 19a-755b, and (D)
41 designating an unclassified individual from the office to perform the
42 duties of a health information technology officer as set forth in sections
43 17b-59f and 17b-59g;

44 (5) Directing and overseeing the Health Systems Planning Unit
45 established under section 19a-612 and all of its duties and

46 responsibilities as set forth in chapter 368z;

47 (6) Convening forums and meetings with state government and
48 external stakeholders, including, but not limited to, the Connecticut
49 Health Insurance Exchange, to discuss health care issues designed to
50 develop effective health care cost and quality strategies; and

51 (7) (A) Administering the Covered Connecticut program established
52 under section 19a-754c in consultation with the Commissioner of Social
53 Services, Insurance Commissioner and Connecticut Health Insurance
54 Exchange, and (B) consulting with the Commissioner of Social Services
55 and Insurance Commissioner for the purposes set forth in section 17b-
56 312.

57 (c) The Office of Health Strategy shall constitute a successor, in
58 accordance with the provisions of sections 4-38d, 4-38e and 4-39, to the
59 functions, powers and duties of the following:

60 (1) The Connecticut Health Insurance Exchange, established
61 pursuant to section 38a-1081, relating to the administration of the all-
62 payer claims database pursuant to section 19a-755a; and

63 (2) The Office of the Lieutenant Governor, relating to the (A)
64 development of a chronic disease plan pursuant to section 19a-6q, (B)
65 housing, chairing and staffing of the Health Care Cabinet pursuant to
66 section 19a-725, and (C) (i) appointment of the health information
67 technology officer, and (ii) oversight of the duties of such health
68 information technology officer as set forth in sections 17b-59f and 17b-
69 59g.

70 (d) Any order or regulation of the entities listed in subdivisions (1)
71 and (2) of subsection (c) of this section that is in force on July 1, 2018,
72 shall continue in force and effect as an order or regulation until
73 amended, repealed or superseded pursuant to law.

74 Sec. 2. (NEW) (*Effective from passage*) For the purposes of this section
75 and sections 3 to 7, inclusive, of this act:

76 (1) "Drug manufacturer" means the manufacturer of a drug that is:
77 (A) Included in the information and data submitted by a health carrier
78 pursuant to section 38a-479qqq of the general statutes, (B) studied or
79 listed pursuant to subsection (c) or (d) of section 19a-754b of the general
80 statutes, or (C) in a therapeutic class of drugs that the executive director
81 determines, through public or private reports, has had a substantial
82 impact on prescription drug expenditures, net of rebates, as a
83 percentage of total health care expenditures;

84 (2) "Executive director" means the executive director of the office;

85 (3) "Health care cost growth benchmark" means the annual
86 benchmark established pursuant to section 3 of this act;

87 (4) "Health care quality benchmark" means an annual benchmark
88 established pursuant to section 3 of this act;

89 (5) "Health care provider" has the same meaning as provided in
90 subdivision (1) of subsection (a) of section 19a-17b of the general
91 statutes;

92 (6) "Net cost of private health insurance" means the difference
93 between premiums earned and benefits incurred, and includes insurers'
94 costs of paying bills, advertising, sales commissions, and other
95 administrative costs, net additions or subtractions from reserves, rate
96 credits and dividends, premium taxes, and profits or losses;

97 (7) "Office" means the Office of Health Strategy established under
98 section 19a-754a of the general statutes, as amended by this act;

99 (8) "Other entity" means a drug manufacturer, pharmacy benefits
100 manager, or other health care provider that is not considered a provider
101 entity;

102 (9) "Payer" means a payer, including Medicaid, Medicare and
103 governmental and nongovernment health plans, and includes any
104 organization acting as payer that is a subsidiary, affiliate or business
105 owned or controlled by a payer that, during a given calendar year, pays

106 health care providers for health care services or pharmacies or provider
107 entities for prescription drugs designated by the executive director;

108 (10) "Performance year" means the most recent calendar year for
109 which data were submitted for the applicable cost growth benchmark,
110 primary care spend target or quality benchmark;

111 (11) "Pharmacy benefits manager" has the same meaning as provided
112 in subdivision (10) of section 38a-479ooo of the general statutes;

113 (12) "Primary care target" means the annual target established
114 pursuant to section 3 of this act;

115 (13) "Provider entity" means an organized group of clinicians that
116 come together for the purposes of contracting, or are an established
117 billing unit that, at a minimum, includes primary care providers, and
118 that collectively, during any given calendar year, has enough attributed
119 lives to participate in total cost of care contracts, even if they are not
120 engaged in a total cost of care contract;

121 (14) "Potential gross state product" means a forecasted measure of the
122 economy that equals the sum of the (A) expected growth in national
123 labor force productivity, (B) expected growth in the state's labor force,
124 and (C) expected national inflation, minus the expected state population
125 growth;

126 (15) "Total health care expenditures" means the sum of all health care
127 expenditures in this state from public and private sources for a given
128 calendar year, including: (A) All claims-based spending paid to
129 providers, net of pharmacy rebates, (B) all patient cost-sharing amounts,
130 and (C) the net cost of private health insurance; and

131 (16) "Total medical expense" means the total cost of care for the
132 patient population of a payer or provider entity for a given calendar
133 year, where cost is calculated for such year as the sum of (A) all claims-
134 based spending paid to providers by public and private payers, and net
135 of pharmacy rebates, (B) all nonclaims payments for such year,

136 including, but not limited to, incentive payments and care coordination
137 payments, and (C) all patient cost-sharing amounts expressed on a per
138 capita basis for the patient population of a payer or provider entity in
139 this state.

140 Sec. 3. (NEW) (*Effective from passage*) (a) Not later than July 1, 2022,
141 the executive director shall publish (1) the health care cost growth
142 benchmarks and annual primary care spending targets as a percentage
143 of total medical expenses for the calendar years 2021 to 2025, inclusive,
144 and (2) the annual health care quality benchmarks for the calendar years
145 2022 to 2025, inclusive, on the office's Internet web site.

146 (b) (1) (A) Not later than July 1, 2025, and every five years thereafter,
147 the executive director shall develop and adopt annual health care cost
148 growth benchmarks and annual primary care spending targets for the
149 succeeding five calendar years for provider entities and payers.

150 (B) In developing the health care cost growth benchmarks and
151 primary care spending targets pursuant to this subdivision, the
152 executive director shall consider (i) any historical and forecasted
153 changes in median income for individuals in the state and the growth
154 rate of potential gross state product, (ii) the rate of inflation, and (iii) the
155 most recent report, if any, prepared by the executive director pursuant
156 to subsection (b) of section 4 of this act.

157 (C) (i) The executive director may hold informational public hearings
158 concerning the benchmarks and targets set pursuant to subsection (a) or
159 subdivision (1) of subsection (b) of this section. Such informational
160 public hearings shall be held at a time and place designated by the
161 executive director in a notice prominently posted by the executive
162 director on the office's Internet web site and in a form and manner
163 prescribed by the executive director.

164 (ii) If the executive director determines, after any informational
165 public hearing held pursuant to this subparagraph, that a modification
166 to any health care cost growth benchmark or annual primary care
167 spending target is, in the executive director's discretion, reasonably

168 warranted, the executive director may modify such benchmark or
169 target.

170 (iii) If the executive director determines that the rate of inflation
171 requires modification of any health care cost growth benchmark
172 adopted under this section, the executive director may modify such
173 benchmark. In such event, the executive director shall not be required
174 to hold an informational public hearing concerning such modified
175 health care cost growth benchmark.

176 (D) The executive director shall post each adopted health care cost
177 growth benchmark and annual primary care spending target on the
178 office's Internet web site.

179 (2) (A) Not later than July 1, 2025, and every five years thereafter, the
180 executive director shall develop and adopt annual health care quality
181 benchmarks for the succeeding five calendar years for provider entities
182 and payers.

183 (B) In developing annual health care quality benchmarks pursuant to
184 this subdivision, the executive director shall consider (i) quality
185 measures endorsed by nationally recognized organizations, including,
186 but not limited to, the National Quality Forum, the National Committee
187 for Quality Assurance, the Centers for Medicare and Medicaid Services,
188 the Centers for Disease Control, the Joint Commission and expert
189 organizations that develop health equity measures, and (ii) measures
190 that: (I) Concern health outcomes, overutilization, underutilization and
191 patient safety, (II) meet standards of patient-centeredness and ensure
192 consideration of differences in preferences and clinical characteristics
193 within patient subpopulations, and (III) concern community health or
194 population health.

195 (C) (i) The executive director may hold informational public hearings
196 concerning the quality measures the executive director proposes to
197 adopt as health care quality benchmarks. Such informational public
198 hearings shall be held at a time and place designated by the executive
199 director in a notice prominently posted by the executive director on the

200 office's Internet web site and in a form and manner prescribed by the
201 executive director.

202 (ii) If the executive director determines, after any informational
203 public hearing held pursuant to this subparagraph, that modifications
204 to any quality benchmarks are, in the executive director's discretion,
205 reasonably warranted, the executive director may modify such quality
206 benchmarks. The executive director shall not be required to hold an
207 additional informational public hearing concerning such modified
208 quality benchmarks.

209 (D) The executive director shall post each adopted health care quality
210 benchmark on the office's Internet web site.

211 (c) The executive director may enter into such contractual agreements
212 as may be necessary to carry out the purposes of this section, including,
213 but not limited to, contractual agreements with actuarial, economic and
214 other experts and consultants.

215 Sec. 4. (NEW) (*Effective from passage*) (a) Not later than August 15,
216 2022, and annually thereafter, each payer shall report to the executive
217 director, in a form and manner prescribed by the executive director, for
218 the preceding or prior years, if the executive director so requests based
219 on material changes to data previously submitted, aggregated data,
220 including aggregated self-funded data as applicable, necessary for the
221 executive director to calculate total health care expenditures, primary
222 care spending as a percentage of total medical expenses and net cost of
223 private health insurance. Each payer shall also disclose, as requested by
224 the executive director, payer data required for adjusting total medical
225 expense calculations to reflect changes in the patient population.

226 (b) Not later than March 31, 2023, and annually thereafter, the
227 executive director shall prepare and post on the office's Internet web
228 site, a report concerning the total health care expenditures utilizing the
229 total aggregate medical expenses reported by payers pursuant to
230 subsection (a) of this section, including, but not limited to, a breakdown
231 of such population-adjusted total medical expenses by payer and

232 provider entities. The report may include, but shall not be limited to,
233 information regarding the following:

234 (1) Trends in major service category spending;

235 (2) Primary care spending as a percentage of total medical expenses;
236 and

237 (3) The net cost of private health insurance by payer by market
238 segment, including individual, small group, large group, self-insured,
239 student and Medicare Advantage markets.

240 (c) The executive director shall annually submit a request to the
241 federal Centers for Medicare and Medicaid Services for the unadjusted
242 total medical expenses of Connecticut residents.

243 (d) Not later than August 15, 2023, and annually thereafter, each
244 payer or provider entity shall report to the executive director in a form
245 and manner prescribed by the executive director, for the preceding year,
246 and for prior years if the executive director so requests based on material
247 changes to data previously submitted, on the health care quality
248 benchmarks adopted pursuant to section 3 of this act.

249 (e) Not later than March 31, 2024, and annually thereafter, the
250 executive director shall prepare and post on the office's Internet web
251 site, a report concerning health care quality benchmarks reported by
252 payers and provider entities pursuant to subsection (d) of this section.

253 (f) The executive director may enter into such contractual agreements
254 as may be necessary to carry out the purposes of this section, including,
255 but not limited to, contractual agreements with actuarial, economic and
256 other experts and consultants.

257 Sec. 5. (NEW) (*Effective from passage*) (a) (1) For each calendar year,
258 beginning on January 1, 2023, the executive director shall identify, not
259 later than May first of such calendar year, each payer or provider entity
260 that exceeded the health care cost growth benchmark or failed to meet
261 the primary care spending target for the performance year. For each

262 calendar year beginning on or after January 1, 2024, the executive
263 director shall identify, not later than May first of such calendar year,
264 each payer or provider entity that failed to meet the health care quality
265 benchmarks for the performance year.

266 (2) Not later than thirty days after the executive director identifies
267 each payer or provider entity pursuant to subsection (a) of this section,
268 the executive director shall send a notice to each such payer or provider
269 entity. Such notice shall be in a form and manner prescribed by the
270 executive director, and shall disclose to each such payer or provider
271 entity:

272 (A) That the executive director has identified such payer or provider
273 entity pursuant to subdivision (1) of this subsection; and

274 (B) The factual basis for the executive director's identification of such
275 payer or provider entity pursuant to subdivision (1) of this subsection.

276 (b) (1) For each calendar year beginning on and after January 1, 2023,
277 if the executive director determines that the annual percentage change
278 in total health care expenditures for the performance year exceeded the
279 health care cost growth benchmark for such year, the executive director
280 shall identify, not later than May first of such calendar year, any other
281 entity that significantly contributed to exceeding such benchmark. Each
282 identification shall be based on:

283 (A) The report, if any, prepared by the executive director pursuant to
284 subsection (b) of section 4 of this act for such calendar year;

285 (B) The report filed pursuant to section 38a-479ppp of the general
286 statutes for such calendar year;

287 (C) The information and data reported to the office pursuant to
288 subsection (d) of section 19a-754b of the general statutes for such
289 calendar year;

290 (D) Information obtained from the all-payer claims database
291 established under section 19a-755a of the general statutes; and

292 (E) Any other information that the executive director, in the executive
293 director's discretion, deems relevant for the purposes of this section.

294 (2) The executive director shall account for costs, net of rebates and
295 discounts, when identifying other entities pursuant to this section.

296 Sec. 6. (NEW) (*Effective from passage*) (a) (1) Not later than June 30,
297 2023, and annually thereafter, the executive director shall hold an
298 informational public hearing to compare the growth in total health care
299 expenditures in the performance year to the health care cost growth
300 benchmark established pursuant to section 3 of this act for such year.
301 Such hearing shall involve an examination of:

302 (A) The report, if any, most recently prepared by the executive
303 director pursuant to subsection (b) of section 4 of this act;

304 (B) The expenditures of provider entities and payers, including, but
305 not limited to, health care cost trends, primary care spending as a
306 percentage of total medical expenses and the factors contributing to
307 such costs and expenditures; and

308 (C) Any other matters that the executive director, in the executive
309 director's discretion, deems relevant for the purposes of this section.

310 (2) The executive director may require any payer or provider entity
311 that, for the performance year, is found to be a significant contributor to
312 health care cost growth in the state or has failed to meet the primary care
313 spending target, to participate in such hearing. Each such payer or
314 provider entity that is required to participate in such hearing shall
315 provide testimony on issues identified by the executive director and
316 provide additional information on actions taken to reduce such payer's
317 or entity's contribution to future state-wide health care costs and
318 expenditures or to increase such payer's or provider entity's primary
319 care spending as a percentage of total medical expenses.

320 (3) The executive director may require that any other entity that is
321 found to be a significant contributor to health care cost growth in this

322 state during the performance year participate in such hearing. Any other
323 entity that is required to participate in such hearing shall provide
324 testimony on issues identified by the executive director and provide
325 additional information on actions taken to reduce such other entity's
326 contribution to future state-wide health care costs. If such other entity is
327 a drug manufacturer, and the executive director requires that such drug
328 manufacturer participate in such hearing with respect to a specific drug
329 or class of drugs, such hearing may, to the extent possible, include
330 representatives from at least one brand-name manufacturer, one generic
331 manufacturer and one innovator company that is less than ten years old.

332 (4) Not later than October 15, 2023, and annually thereafter, the
333 executive director shall prepare and submit a report, in accordance with
334 section 11-4a of the general statutes, to the joint standing committees of
335 the General Assembly having cognizance of matters relating to
336 insurance and public health. Such report shall be based on the executive
337 director's analysis of the information submitted during the most recent
338 informational public hearing conducted pursuant to this subsection and
339 any other information that the executive director, in the executive
340 director's discretion, deems relevant for the purposes of this section, and
341 shall:

342 (A) Describe health care spending trends in this state, including, but
343 not limited to, trends in primary care spending as a percentage of total
344 medical expense, and the factors underlying such trends; and

345 (B) Disclose the executive director's recommendations, if any,
346 concerning strategies to increase the efficiency of the state's health care
347 system, including, but not limited to, any recommended legislation
348 concerning the state's health care system.

349 (b) (1) Not later than June 30, 2024, and annually thereafter, the
350 executive director shall hold an informational public hearing to
351 compare the performance of payers and provider entities in the
352 performance year to the quality benchmarks established for such year
353 pursuant to section 3 of this act. Such hearing shall include an

354 examination of:

355 (A) The report, if any, most recently prepared by the executive
356 director pursuant to subsection (e) of section 4 of this act; and

357 (B) Any other matters that the executive director, in the executive
358 director's discretion, deems relevant for the purposes of this section.

359 (2) The executive director may require any payer or provider entity
360 that failed to meet any health care quality benchmarks in this state
361 during the performance year to participate in such hearing. Each such
362 payer or provider entity that is required to participate in such hearing
363 shall provide testimony on issues identified by the executive director
364 and provide additional information on actions taken to improve such
365 payer's or provider entity's quality benchmark performance.

366 (3) Not later than October 15, 2024, and annually thereafter, the
367 executive director shall prepare and submit a report, in accordance with
368 section 11-4a of the general statutes, to the joint standing committees of
369 the General Assembly having cognizance of matters relating to
370 insurance and public health. Such report shall be based on the executive
371 director's analysis of the information submitted during the most recent
372 informational public hearing conducted pursuant to this subsection and
373 any other information that the executive director, in the executive
374 director's discretion, deems relevant for the purposes of this section, and
375 shall:

376 (A) Describe health care quality trends in this state and the factors
377 underlying such trends; and

378 (B) Disclose the executive director's recommendations, if any,
379 concerning strategies to improve the quality of the state's health care
380 system, including, but not limited to, any recommended legislation
381 concerning the state's health care system.

382 Sec. 7. (NEW) (*Effective from passage*) The executive director may
383 adopt regulations, in accordance with chapter 54 of the general statutes,

384 to implement the provisions of section 19a-754a of the general statutes,
385 as amended by this act, and sections 2 to 6, inclusive, of this act.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	19a-754a
Sec. 2	*from passage*	New section
Sec. 3	*from passage*	New section
Sec. 4	*from passage*	New section
Sec. 5	*from passage*	New section
Sec. 6	*from passage*	New section
Sec. 7	*from passage*	New section

Statement of Purpose:
To implement the Governor's budget recommendations.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]